

## HISTORY FORM

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
           First                          Middle                          Last

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Area of the body you are being seen for? \_\_\_\_\_

Describe injury / accident in detail: \_\_\_\_\_

<u>Medication</u>	<u>Dose</u>	<u>How long taking</u>	<u>Side effects</u>

Allergies: \_\_\_\_\_

Are you currently or have you had problems with your:

	<u>CIRCLE</u>	<u>DESCRIBE ALL YES RESPONSES</u>
Eyes	Yes No	
Ears, Nose, Throat	Yes No	
Lungs, Breathing	Yes No	
Digestion	Yes No	
Bladder	Yes No	
Diabetes	Yes No	
Heart disease	Yes No	
High blood pressure	Yes No	
Bleeding problems	Yes No	
Balance problems	Yes No	
Numbness/tingling	Yes No	
Blackouts/fainting	Yes No	
Psychological problems	Yes No	
Cancer	Yes No	
Arthritis	Yes No	
Polio	Yes No	
Epilepsy	Yes No	
HIV	Yes No	
Hepatitis, Tuberculosis	Yes No	
Other (please describe)	Yes No	